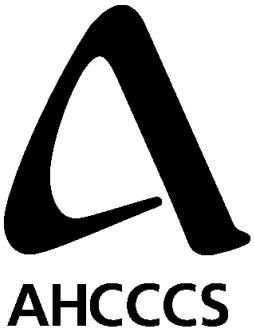
Chapter 9

Hospital and Clinic Services



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NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to acute care hospitals. Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Special Programs at (602) 417-4053. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS web site at www.ahcccs.state.az.us.

INPATIENT HOSPITAL SERVICES

AHCCCS covers medically necessary inpatient hospital services provided by or under the direction of a physician which are ordinarily furnished in a hospital, except for services in an institution for tuberculosis or mental diseases. Inpatient services at Indian Health Service (IHS) and 638 tribal hospitals are covered for AHCCCS/ALTCS recipients when the recipient's condition requires hospitalization because of the severity of illness and intensity of services required.

☑ Covered hospital accommodation services include:

- ✓ Maternity care
- ✓ Medical/surgical care unit
- ✓ Nursery and neonatal intensive care nursery
- ✓ Intensive care and coronary care unit
- ✓ Nursing services necessary and appropriate for the recipient's condition
- ✓ Dietary services
- ✓ Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients that are billed as part of the daily room and board charge

☑ Covered ancillary services include:

- ✓ Labor, delivery, observation rooms, and birthing centers
- ✓ Procedure, operating, and recovery rooms
- ✓ Laboratory services
- ✓ Radiology and medical imaging services
- ✓ Anesthesiology services
- ✓ Rehabilitation services, including physical, occupational, and speech therapies
- ✓ Pharmaceutical services and prescribed drugs

INPATIENT HOSPITAL SERVICES (CONT.)

☑ Covered ancillary services include (Cont.):

- ✓ Respiratory therapy
- ✓ Services and supplies necessary to store, process, and administer blood and blood derivatives
- ✓ Central supply items, appliances, and equipment ordinarily furnished to all patients and customarily reimbursed as ancillary services
- ✓ Maternity services
- ✓ Nursery and related services
- ✓ Chemotherapy
- ✓ Dialysis
- ✓ Total parenteral nutrition services (TPN)
- ✓ Dental surgery for EPSDT recipients
- ✓ Podiatry services ordered by a physician or PCP

☑ Exclusions and limitations

- ✓ Inpatient dialysis treatments are covered only when the hospitalization is for:
  - ☒ An acute medical condition requiring hemodialysis treatments.
  - ☒ A medical condition experienced by a recipient routinely maintained on an outpatient chronic dialysis program.
  - ☒ Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).
- ✓ Personal comfort items are not covered.
- ✓ Professional services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

BILLING OF INPATIENT CLAIMS

Inpatient hospital claims from IHS and 638 tribal facilities must be submitted to the AHCCCS Administration on UB-92 claim forms (See Chapter 5, Claim Form Requirements for UB-92 billing instructions).

Inpatient services for Title XIX (Medicaid) and Title XXI (KidsCare) recipients are billed with two revenue codes:

- ☑ 100 – All-inclusive Room and Board
- ☑ 001 – Total Charges

IHS facilities approved for an NICU rate with AHCCCS must use NICU revenue codes to bill for NICU services.

Claims also must meet the minimum data requirements prescribed by AHCCCS and include at least:

- ☑ The AHCCCS provider identification number.
- ☑ The AHCCCS recipient identification number.
- ☑ The date of admission
- ☑ The beginning date and ending dates of the service provided
- ☑ The primary ICD-9 diagnosis that required the service
- ☑ An appropriate inpatient hospital bill type

AHCCCS pays for the date of admission up to but not including date of discharge unless the patient expires.

Example 1:

Dates of service: 03/05 through 03/10 Accommodation days billed: 5

Bill type: 111 Patient status: 01

AHCCCS will reimburse five days. The date of discharge will not be paid when the patient status indicates a status other than expired.

Example 2:

Dates of service: 03/05 through 03/10 Accommodation days billed: 6

Bill type: 111 Patient status: 20

AHCCCS will reimburse six days because the patient status indicates expired.

BILLING OF INPATIENT CLAIMS (CONT.)

Example 3:

Dates of service: 03/05 through 03/10 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days. AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient).

Example 4:

Dates of service: 03/05 through 03/10 Accommodation days billed: 2

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days. The provider billed only two accommodation days. AHCCCS will reimburse the number of accommodation days billed up to the maximum allowed for the dates of service.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

AHCCCS reimburses claims from IHS and 638 tribal facilities in one of two ways:

- ☑ IHS per diem rate
  - ✓ This rate is established by the federal Office of Management and Budget (OMB)
- ☑ Coinsurance and/or deductible
  - ✓ Used to reimburse providers when Medicare is the primary payer and has made payment on the claim

OUTPATIENT FACILITY SERVICES

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative services or items ordinarily provided on an outpatient basis for all recipients within certain limits based on recipient age and eligibility.

☑ Covered outpatient services include:

- ✓ Medically necessary outpatient hospital and clinic services
- ✓ Emergency room services
- ✓ Ambulatory surgery center (ASC) services
- ✓ Laboratory services
- ✓ Medical supplies and equipment ordinarily furnished to persons receiving outpatient services to the extent that they are covered services and ordered by a physician
- ✓ Pharmaceutical services and prescribed drugs
- ✓ Radiology and medical imaging services
- ✓ Physician services (including ambulatory surgery, specialty care, and home visits)
- ✓ Nurse midwife services
- ✓ Dental surgery for EPSDT eligible recipients
- ✓ Outpatient podiatry services performed by a licensed podiatrist when ordered by a primary care physician
- ✓ Rehabilitation services, excluding occupational therapy and speech therapy for recipients 21 years of age or older
- ✓ Services of allied health professionals when referred by or under the supervision of a physician
- ✓ Dialysis
- ✓ Total parenteral nutrition (TPN) services

If a recipient is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

BILLING AND REIMBURSEMENT OF OUTPATIENT SERVICES

☑ IHS/638 tribal **hospital** outpatient surgery claims for **Title XIX (Medicaid) recipients**

- ✓ Outpatient surgery claims for Title XIX (Medicaid) recipients are billed on the UB-92 claim form (837I for electronic claims).
- ✓ Use revenue code 490 and bill type 83X.
- ✓ Enter the CPT code for the surgical procedure in the HCPCS/Rates field (Field 44).
- ✓ The AHCCCS Claims System will classify the procedure at the appropriate IHS ASC level and reimburse the claim accordingly.
- ✓ The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services)

☑ IHS/638 tribal **hospital** outpatient surgery claims for **Title XXI (KidsCare) recipients**

- ✓ Outpatient surgery claims for Title XXI (KidsCare) recipients are billed on the UB-92 claim form (837I for electronic claims) with appropriate revenue codes.
- ✓ Claims are reimbursed by multiplying covered charges by the statewide outpatient cost-to-charge ratio
- ✓ The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services)

☑ IHS/638 tribal **clinic** outpatient surgery claims for **Title XIX (Medicaid) recipients**

- ✓ Outpatient surgery claims for Title XIX (Medicaid) recipients are billed on the UB-92 claim form (837I for electronic claims).
- ✓ Use revenue code 490 and bill type 83X.
- ✓ Enter the CPT code for the surgical procedure in the HCPCS/Rates field (Field 44).
- ✓ The AHCCCS Claims System will classify the procedure at the appropriate ASC level and reimburse the claim accordingly.
- ✓ The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services)

☑ IHS/638 tribal **clinic** outpatient surgery claims for **Title XXI (KidsCare) recipients**

- ✓ Outpatient surgery claims for Title XXI (KidsCare) recipients are billed by the *individual practitioner* on the CMS 1500 claim form with CPT codes. (See Chapter 8, Individual Practitioner Services)
- ✓ Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

BILLING AND REIMBURSEMENT OF OUTPATIENT SERVICES (CONT.)

☑ All other hospital and clinic outpatient services for **Title XIX (Medicaid) recipients**

- ✓ Bill all other hospital and clinic outpatient services for Title XIX (Medicaid) recipients on a UB-92 claim form (837I for electronic claims) using the appropriate clinic (medical or dental) revenue code (51X).
- ✓ Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge)
- ✓ Enter the outpatient OMB rate in the Total Charges field (Field 47).
- ✓ The AHCCCS Claims System will reimburse the service at the outpatient OMB rate.

☑ All other hospital outpatient services for **Title XXI (KidsCare) recipients**

- ✓ All other hospital outpatient services for Title XXI (KidsCare) recipients are billed on the UB-92 claim form (837I for electronic claims) with appropriate revenue codes.
- ✓ Claims are reimbursed by multiplying covered charges by the statewide outpatient cost-to-charge ratio

☑ All other clinic outpatient services for **Title XXI (KidsCare) recipients**

- ✓ All other clinic outpatient services (except dental) for Title XXI (KidsCare) recipients are billed by the individual practitioner (physician, nurse practitioner, etc.) on the CMS 1500 with HCPCS/CPT codes.
- ✓ Outpatient dental services for Title XXI (KidsCare) recipients are billed by the individual practitioner dentist on the ADA 2002 claim form with CDT-4 codes.
- ✓ Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

BILLING FOR OBSERVATION SERVICES

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. Covered observation services include:

☑ Use of a bed

☑ Periodic monitoring by the hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

BILLING FOR OBSERVATION SERVICES (CONT.)

☑ IHS and 638 tribal hospitals must bill for observation services for **Title XIX (Medicaid) recipients** on the UB-92 claim form (837I for electronic claims) following the instructions for other outpatient services above.

- ✓ AHCCCS will reimburse the observation services at the outpatient OMB rate.

☑ IHS and 638 tribal hospitals must bill for observation services for **Title XXI (KidsCare) recipients** on the UB-92 claim form and must bill with a 762 revenue code (Treatment/ Observation Room - Observation Room).

- ✓ Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

  Example: Billing observation services

  A recipient is placed in observation status at 2:25 p.m. and sent home at 7:45 p.m. The hospital would submit a UB-92 claim to AHCCCS as follows:

Revenue Code	762
Units	6

  Each unit of observation services equals one hour or portion of an hour. The recipient was in observation status for five hours and 20 minutes, which equals six units.

Observation services that directly precede an inpatient admission to the same hospital must not be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced at the per diem rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the tiered per diem payment.

GROUP BILLING

☑ IHS and 638 tribal hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners.

☑ In these cases, the claim will carry both the physician/mid-level practitioner ID as the service provider and the hospital or clinic group biller ID.

☑ See Chapter 3, Provider Records and Registration, for information on registering as a group biller.